Is the Presence or Absence of *Helicobacter pylori* in Gastric Mucosa a Greater Risk

Sir,

We have read with interest Gupte and Desai’s update article about risk assessment of *Helicobacter pylori* (H. pylori) in gastric mucosa.1 After we read the article, we wanted to say something about H. pylori related to hematology. A number of studies have reported the presence of H. pylori in patients with idiopathic thrombocytopenic purpura (ITP) and H. pylori eradication therapy was recently approved for treatment of H. pylori-positive ITP patients. H. pylori eradication increases platelet counts in most H. pylori-infected ITP patients resistant to other therapies.2-4 However, other studies have generated conflicting data.5 British Society for Haematology in guidelines for the investigation and management of ITP recommended that it is worth determining the presence of H. pylori in patients refractory to therapy since some patients have shown improvement in platelet counts following eradication therapy (Evidence level III, Grade B recommendation).6 The recently published review of Jackson et al. that showed the possible implication of H. pylori infection in ITP.7 Several theories in this review were evaluated to explain the platelet response to H. pylori eradication therapy. H. pylori eradication has few adverse effects and its cost is low, and therefore H. pylori eradication should be attempted in H. pylori-positive patients with ITP. In addition its role on ITP, it has been shown that H. pylori is a causative agent in the development of adult vitamin B12 deficiency, and eradication of H. pylori infection alone may correct vitamin B12 levels.8 It may be speculated that association of vitamin B12 deficiency and H. pylori infection is coincidental, but restoration of vitamin B12 deficiency may benefit from H. pylori eradication, though it is controversial, as indicated by authors.

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Reply from the Author

Sir,

We agree with the observations made by the authors. Our observations were restricted to diseases of oesophagus-stomach-duodenum. The emphasis was on H. pylori and vitamin B12 deficiency. Occasional patient of ITP or vitamin B12 deficiency may benefit from H. pylori eradication, though it is controversial, as indicated by authors.

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Chlamydia pneumoniae - Seroprevalence Among Adults Presenting with Acute Community-Acquired Pneumonia (CAP)

Sir,

*Mycoplasma, Legionella* and *Chlamydia* have emerged as major treatable “atypical agents” causing pneumonias in adults1 and such infections are characterized by failure to respond to betalactam antimicrobials. In a prospective study of adult Community Acquired Pneumonia(CAP) we had earlier shown seroprevalence rates of 14% for *Mycoplasma* and *Legionella* together.2 However, the seroprevalence of CAP caused by *C. pneumoniae* has not been ascertained in this region. The isolation of *C. pneumoniae* is laborious and expensive, but indirect and valuable supporting evidence can be obtained using serological tests like

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The microimmunofluorescence test (MIFT) for IgG and IgM antibodies detection. This study was undertaken to determine the seroprevalence of \textit{C. pneumoniae} causing CAP among adults.

Eighty consecutive adults (age > 12 years) with clinical symptoms, signs and radiological evidence of acute CAP (duration < 4 weeks) presenting to our tertiary care center were enrolled. Clinical symptoms for inclusion were: (i) fever (\(>100^\circ\text{F}\)) and cough; (ii) any one of the following symptoms - chest pain, breathlessness, sputum expectoration, hemoptysis, or wheeze; and (iii) radiological evidence of infiltrates, segmental or subsegmental consolidation, or parapneumonic effusion. Patients with chronic pneumonia (duration > 4 weeks), suppurative lung conditions, active pulmonary tuberculosis, aspiration or hospital acquired pneumonias, were excluded. Sera were stored at -20°C until further testing.

\textit{C. pneumoniae} specific IgG and IgM antibodies were tested using the MIFT.\textsuperscript{3} This is an indirect fluorescent test where serially diluted patients serum was tested against a mixture of several different antigens of \textit{Chlamydia pneumoniae} fixed on glass slide. The antibody specific class was assessed by commercially available conjugates of IgM or IgG, labeled with fluorescent isothiocyanate. The highest serum dilution exhibiting fluorescence along with their clinical presentation leads to believe that the etiology of pneumonia in these patients may be due to \textit{Chlamydia pneumoniae}.

With our previous report of \textit{Mycoplasma} and \textit{Legionella} seroprevalence rates to be 14% together, and this study with a \textit{C. pneumoniae} seroprevalence of about 6.5% of adults presenting with acute CAP. Our study has limitation in that for the majority of our patients convalescent sera could not be obtained and higher dilutions (>1:8) of IgM positive patients could not be tested. Of the five positive patient samples, three showed a 4+ reaction. This strong fluorescence along with their clinical presentation leads us to believe that the etiology of pneumonia in these patients may be due to \textit{Chlamydia pneumoniae}.

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### References


### Time to Thrombolysis in Patients with Acute Myocardial Infarction in a Tertiary Referral Centre: An Important Performance Indicator in an Emergency Department

Sir,

Acute myocardial infarction (AMI) is amongst the topmost medical emergencies presenting to the Emergency Department (ED) in which every single minute is of immense value. Early thrombolytic therapy is the cornerstone of the treatment of AML.\textsuperscript{1} Prompt treatment of patients with AMI decreases death from early arrhythmias and maximizes potential benefit of thrombolytic therapy.\textsuperscript{2,4} Very early treatment with a thrombolytic agent results in a substantial (30-70%) reduction in infarct size. More than half of this effect is lost when the treatment is delayed by more than 60-75 minutes.\textsuperscript{5} In India, the pre-hospital emergency medical services are not developed and pre-hospital thrombolysis is not established. Hence most of the patients having AMI receive thrombolysis only after reaching the secondary or tertiary level hospitals where Intensive Coronary Care Units (ICCU) are available.

Limited number of tertiary referral hospitals in India have a comprehensive ED fully equipped to administer thrombolytic therapy to patients with AMI. Since AMI is a major health problem and the outcome depends on the promptness of thrombolytic therapy, we studied the time to thrombolysis in patients with AMI as a performance indicator (PI) of the ED at a tertiary referral hospital in Mumbai city with a turnover of over 600 patients per day. Most of such studies have been conducted in the developed world where greater awareness, availability of helplines and prompt ambulance services are available. No studies on PI in the EDs are available from India, as the practice and documentation of quality parameters is not in place in most of the EDs in India.

In the present study, we analyzed the factors affecting the time to thrombolysis (onset of chest pain to thrombolysis) as well as door to thrombolysis (time gap from reaching the hospital to thrombolysis) in a tertiary referral centre from the perspective of a developing country where multiple hospital-related as well as socioeconomic factors may be responsible for pre-hospital and in-hospital time-lags in thrombolysis.

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